UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Xolegel (ketoconazole)

Patient name:_____Medicaid or SS# _____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and opt._____ Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

CRITERIA:

- Minimum age: 12 years old.
- Documented trial and failure of a generic formulation of topical ketoconazole within the last 12 months.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy